STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045345	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Fort Smith Rehab & Nursing Center	5301 Wheeler Avenue Fort Smith, AR 72901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Number of residents sampled:1Number of residents cited:1Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure a resident was not allowed to self- administer their medications for 1 (Resident #7) of 6 sampled residents (R#1, R#7, R#13, R#16 R#30 and R#72) who reside in a secure neighborhood.Findings include:Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to ensure a resident was clinically appropriate to self- administer medications for one (Resident #7) of six residents reviewed. The findings include: During an observation on 09/15/2025 at 1:30 PM, Resident #7 was lying in bed. As they talked to this surveyor they reached into their bedside table drawer and got out a box, with a prescription label on it, which contained a nasal spray, they then placed it back in the drawer. During a concurrent observation and interview on 09/16/2025 at 9:04 AM, Resident #7 was sitting on their bed as they talked with this surveyor, Resident #7 reached over to their overbed table and picked up a plastic medication cup which contained four unidentified medications as follows: a small round burnt-orange pill; a mustard-colored oval pill; a yellow small oval pill and a white round tablet. Resident #7 stated to this surveyor that they took their thyroid medication before breakfast and took the rest of the medications after they ate breakfast, so staff just left them on the overbed table in the cup until then. Review of Resident #7's admission Record, indicated the facility admitted Resident #7 on 07/03/2025 with diagnoses which included bipolar disorder, dementia with behavior disturbances (decline in cognition, memory, thinking and reasoning with behavior issues), hypothyroidism (low production of thyroid hormone from the thyroid gland), and allergic rhinitis (inflammation of nasal passages caused by allergies). Review of Resident #7's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/2025, indicated Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also indicated the resident was taking antipsychotic, antianxiety, and anticonvulsant medications on a routine basis. Review of Resident #7's Care Plan, revised on 07/31/2025, indicated the resident was noncompliant with medications at times, refused medications, and would pick & choose which medications they wanted to take. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #7's Physician's Orders for September 2025, indicated an active order that all meds may be given at one time and that Resident #7 may not self-administer medications. Review of Resident #7's Medication Administration Record (MAR) for September 16th, 2025, revealed Resident #7 had received their morning medication at 8:00 AM. During an interview on 09/16/2025 at 9:13 AM, Licensed Practical Nurse (LPN) #2 accompanied this surveyor to Resident #7's room, where a confused resident had entered Resident #7's room and the four medications remained on the overbed table. LPN #2 confirmed medications should not be left in residents' rooms, and that any resident could get them. On 09/19/2025 at 9:25 AM, the Assistant Director of Nursing (ADON) indicated that medications should not be left with a resident because any resident could wander into the room and take them, and that the nurse needs to ensure medications were taken to maintain a therapeutic level of medications. The Administrator, who was present for this interview, voiced agreement with the ADON's statement. On 09/19/2025 at 10:15 AM, the Director of Nursing (DON) confirmed the expectation was medications were to be given in compliance with Physician Orders, following the rights of medications administration, and that the nurse who administered the medications would ensure the medications were swallowed. The DON confirmed if the medication was not given by Physician Order, that would be an error. Review of a facility policy titled, Medication Administration, revised on 11/25/2022, indicated, only persons licensed or permitted to prepare, administer and document the administration of medications may do so. a resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team has determined that they have the decision-making capacity to do so safely.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Number of residents sampled:1Number of residents cited:1Based on observations, interviews, record reviews, facility records and policy review the facility failed to ensure physician orders were consistently implemented for 1 (resident #111) of 1 final sample resident reviewed for position and mobility. The findings are:Based on observations, record review, and interviews, it was determined that the facility failed to ensure Physician Orders were consistently implemented for one (Resident #111) of one resident reviewed for position and mobility. The findings include: During an observation on 09/15/2025 at 1:19 PM, this surveyor observed Resident #111 sitting up in a chair in the residents' room after lunch. Resident #111's left hand was closed tightly with their thumb between the first and second finger and the arm was held close to the body. No handroll or splint was observed in the hand. A basket sitting in the room on a shelf held both a Handroll Carrot [a carrot shaped soft fabric device held within the hand to prevent contracture] and a splint [a device with hook and loop straps that fit a specific resident]. Certified nursing assistant (CNA) #10 had just finished assisting Resident #111 with the lunch meal and was asked if the resident could open the left hand. CNA #10 reported that Resident #111 could not open the left hand. CNA #10 indicated that Resident #111 had a carrot for the hand. This surveyor asked CNA #10 to ask the resident to demonstrate the ability to open the left hand, Resident #111 was unable to comply with opening the left hand. This surveyor asked CNA #10 when Resident #111 wore the handroll or splint and CNA #10 reported the Restorative Nurse Aide's (RNA's) applied it, but I do not know when. During an observation on 09/18/2025 at 12:34 PM, Resident #111 was observed sitting up in the dining room without a handroll carrot or splint in the left hand. Resident #111's left hand was held closed tightly and close to the chest. During an observation on 09/18/2025 at 2:10 PM, Resident #111 was observed sitting up in the day area, without a splint or hand roll in their left hand, the hand was closed tightly and held close to the chest. Review of an Annual Minimum Data Set with an Assessment Reference date of July 2, 2025, for Resident #111, indicated Resident #111 had a Brief Interview for Mental Status score of 00, which indicated the resident had severe cognitive impairment. The MDS also indicated Resident #111 had upper extremity limitation with functional range of motion. Review of an Order Summary Report active as of 09/18/2025, indicated Resident #111 had diagnoses which included decline in cognitive ability such as memory, thinking and reasoning affecting daily life. The Order Summary also included an active order as of 04/23/2025 for handrolls or equivalent to be applied to the effected hand daily every shift. Review of a Care Plan Report indicated Resident #111 had an alteration in their musculoskeletal status related to contracture. Resident #111 had a left-hand contracture with an initiated date of 04/24/2024. Resident #111's interventions included assisting the resident with the use of supportive devices (hand rolls) as recommended with an initiated date of 04/24/2025. (continued on next page)

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The Blossoms at Fort Smith Rehab & Nursing Center	5301 Wheeler Avenue Fort Smith, AR 72901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Job Description for the position of Restorative Nursing Aide (RNA) indicated the RNA was responsible for providing nursing restorative care to ensure residents attain or maintain the highest possible physical wellbeing without decline. The RNA will provide care in accordance with the residents' Care Plan. Essential job functions included the following: -Assist residents to apply and remove splints or prosthesis. -Provide good body alignment with use of positioning device and contracture padding as appropriate. -Adhere to personnel policies. -Understand special needs and limitations of the elderly. Review of a Contracture List indicated that Resident #111 was on the RNA daily task list for left handrolls. Review of a sign off RNA Task-Contracture Care for Resident #111, from 8/20/2025 through 9/18/2025, indicated that out of 90 shifts possible, the splint applied box was checked 17 times, the resident refused 21 times and Not Applicable (NA) was checked 48 times. During an interview on 09/18/2025 at 1:09 PM, the Director of Nursing (DON) confirmed a Physician Order for hand rolls or equivalent to affected hand or hands daily every shift indicated that the resident should be wearing the hand roll or equivalent all day every day. During an interview on 09/18/2025 at 2:14 PM, LPN #7 was asked to review Resident #111's Physician Order for the handrolls. LPN #7 reviewed the Physician's Order in the Electronic Medical Record (EMR) for Resident #111, LPN #7 stated that it meant the hand roll should always be in Resident #111's hand. LPN #7 reported that the restorative Nursing assistants usually inserted the hand rolls, but the CNAs could also place them. LPN #7 was asked to observe Resident #7 while sitting in the day room, when LPN #7 observed the absence of a handroll, LPN #7 reported that they would ensure a handroll would be placed as soon as possible. During an interview on 09/18/2025 at 3:16 PM, RNA #5 and RNA #6 stated that when the NA box was checked on the sign off sheet for RNA task, it indicated that they did not have time to perform the activity. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/18/2025 at 3:16 PM RNA #6 stated when stepping out of a room at the end of the hall with RNA #5, we were shredding paper. This surveyor observed several bags of shredded paper and documents in boxes in the room the RNAs came out of. RNA #6 confirmed being trained to complete each resident's functional maintenance plan, and Resident #111 should always have a handroll or splint in the left hand. RNA #6 reported Resident #111 had a handroll in when she last checked the resident. RNA #6 was unsure of the time. RNA #6 indicated Resident #111 would pull the handroll out. RNA #6 confirmed that the RNA's were trained to follow the Physician's Order and that according to Resident #111's order, they were supposed to have a hand roll, carrot or a splint in every day. RNA #6 reported documentation was completed in the task section of the EMR. RNA #6 indicated the DON had been notified within the last two months verbally that the RNA's didn't have enough time to complete their tasks and were informed to do their best. RNA #6 reported that they were required to spend at least one hour a day on their eight-hour shift, shredding paper from the Administrator. During an interview on 09/18/2025 at 3:16 PM, RNA #5 confirmed that the RNA's were shredding paper prior to the interview. RNA #5 reported that the RNA's were trained to follow the Physician's Orders and that Resident #111 should have a handroll or splint in the left hand all day every day, except when in the shower. RNA #5 explained that when the handroll or splint was documented, in the task section of the EMR, a check in the box for yes indicated the handroll or splint was placed, a check in the resident refused meant the resident refused and a check in the NA box meant they did not have time to complete the functional maintenance plan. RNA #5 confirmed the DON had been informed during the times that the tasks could not be completed, and the RNAs were informed to do their best. During an interview on 09/19/25 at 10:09 AM, the DON indicated the RNA's have certain tasks assigned but were not certain of their daily schedule. The DON indicated the RNA's assist with unloading the truck, stocking the personal care supplies, deliver briefs to individual residents, weigh residents then perform their functional maintenance duties. The DON reported being aware that there was a problem with the RNA's completing Physician Ordered functional maintenance plans. During an interview on 09/19/25 at 10:40 AM, CNA #11 reported the RNA's usually set up their day to accommodate the residents on their list. The RNAs were responsible for assisting residents in the dining room, weighing residents, delivering supplies and completing their functional maintenance plans. The RNA's usually shred paper on Friday if they have nothing else to do. This surveyor handed CNA #11 task sheet for splint placement for Resident #111 and asked to explain what a check in the NA box meant. CNA #11 reported not knowing what it meant, and a blank area meant the task was not completed. CNA #11 reported that the RNA task completion was monitored by rounding and interviewing residents but denied any documentation of monitoring rounds. CNA #11 indicated these monitoring rounds were made three-four times a day. CNA #11 reported that RNA #5 and RNA #6 were both trained for their positions and were retrained every 30 to 90 days as well as yearly competency checks. During an interview on 09/19/25 at 10:44 AM, the Administrator indicated that along with their functional maintenance plan, the RNA's were responsible for stocking personal care supplies and weighing residents. The Administrator confirmed his expectation that the RNA's follow each resident's functional maintenance plan. This surveyor did request any facility policies related to implementing Physician Orders. No facility policies were provided.

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The Blossoms at Fort Smith Rehab & Nursing Center	5301 Wheeler Avenue Fort Smith, AR 72901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Number of residents sampled:3Number of residents cited:2Based on observations of the 8:00 AM medication administration, interviews, record reviews and facility policy review, it was determined that the facility failed to ensure medications were administered according to the physician's orders for 2 (residents #30 and #85) of 3 residents who were observed during medication administration.The findings are:Based on observations, interviews, record reviews and facility policy reviews, it was determined that the facility failed to ensure medications were administered according to the physician's orders for two (Resident #30 and Resident #85) of three residents who were observed during medication administration, resulting in two medication errors in thirty-six opportunities, with a total error rate of 5.56%. The findings include: Resident #85 During an observation and concurrent interview on 09/17/2025 at 8:09 AM, LPN #3 gathered Resident #85's medication cards and bottles, checked them with the Electronic Medical Record (EMR), withdrew one multivitamin tablet from its bottle, and administered the multivitamin to Resident #85. LPN#3 confirmed that all medications ordered for Resident #85 had been administered at the completion of the observation. When the medications were reconciled with the Physician's Orders, the order was indicated to be for a multivitamin with minerals. Review of an admission Record for Resident #85 indicated the facility admitted Resident #85 on 09/15/2025 with diagnoses which included weakened immune system, diabetes mellitus, obesity and lipoprotein deficiency. Review of an Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/30/2025 indicated Resident #85 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #85 was cognitively intact. Review of an Order Summary Report for Resident #85 indicated a multivitamin with minerals be given one tablet by mouth one time a day for supplement. During an interview on 09/19/25 at 10:09 AM, the DON reported that plain multivitamins are different from multivitamins with minerals that were ordered for Resident #85. Resident #85 should have received the Physician Ordered multivitamin with minerals. Resident #30 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 09/18/2025 at 8:06 AM, Registered Nurse (RN) #4 placed a needle on an insulin flex pen, RN #4 then dialed up two units and while holding the pen horizontally, depressed the plunger toward the medication cart, nothing was observed exiting the insulin pen. RN #4 then dialed up the sliding scale dose of four units and the routine dose of ten units before meals dose to equal 14 units. RN #4 administered the dialed dose to Resident #30's abdomen, depressed the plunger then released the plunger holding the pen to the skin for a count by the surveyor of six. After the administration, RN #4 was asked to explain the purpose of priming the insulin pen and the RN reported the purpose of priming the insulin pen was to relieve any air bubbles. When RN #4 was asked to explain how the pen should be primed, RN #4 reported that two units should be dialed up and ejected. RN#4 did not indicate the pen should be pointed up in a vertical position. RN #4 reported that when the pen was primed according to manufacturer instructions, that a drop of insulin should be seen otherwise the step should be repeated. RN#4 confirmed being trained on the proper procedure for administration of an insulin pen. Review of an admission Record for resident #30 indicated the facility admitted Resident #30 on 07/20/2018 with diagnoses which included diabetes mellitus type 2. Review of a Quarterly MDS with an ARD of 7/14/2025 indicated Resident #30 had a BIMS score of 08 which indicated Resident #30 had severe cognitive impairment. Review of an Order Summary Report was reviewed for Resident #30, indicated a Physicians Order for Aspart insulin flex pen subcutaneous solution 100 UNIT/ML [milliliter] inject as per sliding scale as follows: 150 - 200 = 2; 201 - 250 = 4; 251 – 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 - 450 = 12 notify physician, subcutaneously before meals and at bedtime. Initiated 9/17/2025. Physician Order also indicated to administer Insulin Aspart Solution 100 UNIT/ML as follows: Inject 10 units subcutaneously with meals for diabetes before breakfast, hold if Capillary Blood Glucose (CBG) less than 90 or resident not eating. Review of a Laboratory Report dated 9/10/2025 for Resident #30 indicated a Glycated Hemoglobin Percentage (HbA1c %) result of 9.1H [high, normal 4.4-6.1%]. During an interview on 09/19/2025 at 10:00 AM, the Advanced Practice Nurse (APN) reported that Resident #30 had a diagnosis of diabetes, insulin prescribed and recently had lab that resulted in an elevated HbA1c and due to the residents' comorbidities could be negatively affected if the resident's insulin dose was not correct. The APN reported that medication administration staff are expected to administer Physician Ordered medications correctly and to follow the facility policy. The APN was asked how she provided instructions for patients related to the priming and administering of an insulin pen. She stated, I always instruct my patients to prime the pen with the point up and to hold the plunger in for a count of 5 or 6 seconds. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/25 at 10:09 AM, the Director of Nursing (DON) indicated the expectation for medication administration was for medications to be administered properly, following the medication rights and per the Physician's Orders. The DON reported that if the medication was not administered as ordered that would be a medication error. The DON confirmed that if an insulin pen was not primed correctly there would be potential for an inaccurate dose administered and the resident would not receive the ordered dose. The DON confirmed that all medications should be administered as ordered by the provider and that staff are expected to follow facility policy. The DON also confirmed that nursing competencies for medication administration were completed on hire, yearly, and as needed, and that RN #4 and LPN #3 had completed the competencies on 10/27/2025 [LPN#3] and 10/28/2025 [RN#4]. The DON reported that both LPN #3 and RN #4 had completed the competencies and were identified as being able to competently administer medications. During an interview on 09/19/25 at 10:44 AM, the Administrator reported his expectation of medications to be administered were for the medications to be administered according to Physician's Orders. The Administrator confirmed that if the medication was not administered according to the Physicians Orders, it would be considered a medication error. The expectation for staff was for them to follow the facility policies. The Administrator reported nursing competencies were performed on hire, yearly, and as needed. Review of a facility policy titled, Medication Administration with a revised date of 11/25/22, indicated that medications would be administered as prescribed to maintain a medication error rate less than 5%. Medications must be administered according to Physician's Orders. The staff administering the medications must check the label three times to ensure the right resident, right medication, right dose, right time and right method of administration prior to the administration of the medication. Review of manufacturer's Instructions for Use guidelines revealed in Step 7, Priming your FIASP FlexTouch Pen: Turn the dose selector to select 2 units. Step 8, Hold the Pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold ibn the dose button until the counter shows 0. A drop pf insulin be seen at the needle tip. If you do not see a drop of insulin, repeat steps 7 to 9.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Number of residents sampled:1Number of residents cited:1Based on observation of the 8:00 AM medication administration, interviews, record reviews and facility policy review the facility failed to ensure that an insulin pen was prepared and administered according to manufacturer's instructions for 1 (resident #30) of 1 resident observed for insulin administration. The findings are: Based on observation, interviews, record reviews and facility policy review, it was determined that the facility failed to ensure that an insulin pen was prepared and administered according to manufacturer's instructions for one (Resident #30) of one resident observed for insulin administration. The findings include: During an observation of medication administration on 09/18/2025 at 8:06 AM for Resident #30, this surveyor observed Registered Nurse (RN) #4 placed a needle on the Aspart flex pen insulin. RN #4 then dialed up two units and while holding the pen horizontally, depressed the plunger toward the medication cart, nothing was observed exiting the insulin pen. RN #4 then dialed up the sliding scale dose of four units and the routine dose of ten units before meals dose to equal 14 units. RN #4 administered the dialed dose to Resident #30's abdomen, depressed the plunger then released the plunger holding the pen to the skin for a count by the surveyor of sic seconds. After the administration, RN #4 was asked to explain the purpose of priming the insulin pen and the RN reported the purpose of priming the insulin pen was to relieve any air bubbles. When RN #4 was asked to explain how the pen should be primed, RN #4 reported that two units should be dialed up and ejected. RN #4 did not indicate the pen should be pointed up in a vertical position. RN #4 reported that when the pen was primed according to manufacturer instructions, that a drop of insulin should be seen, otherwise the step should be repeated. RN #4 confirmed being trained on the proper procedure for administration of an insulin pen. Review of an admission Record for Resident #30, indicated the facility admitted Resident #30 on 07/20/2018 with diagnoses which included diabetes mellitus type 2. Review of a quarterly Minimum Data Set with an Assessment Reference Date of 7/14/2025 indicated Resident #30 had a Brief interview for mental status score of 08 [00-08 indicated severe cognitive impairment]. Review of an Order Summary Report was reviewed for Resident #30, indicated a Physicians Order for Aspart insulin flex pen subcutaneous solution 100 UNIT/ML [milliliter] inject as per sliding scale as follows: 150 - 200 = 2; 201 - 250 = 4; 251 – 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 - 450 = 12 notify physician, subcutaneously before meals and at bedtime. Initiated 9/17/2025. Physician Order also indicated to administer Insulin Aspart Solution 100 UNIT/ML as follows: Inject 10 units subcutaneously with meals for diabetes before breakfast, hold if Capillary Blood Glucose (CBG) less than 90 or resident not eating. Review of a Laboratory Report dated 9/10/2025 for Resident #30 indicated a Glycated Hemoglobin Percentage (HbA1c %) result of 9.1H [high, normal 4.4-6.1%]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/2025 at 10:00 AM, the Advanced Practice Nurse (APN) reported that Resident #30 had a diagnosis of diabetes, insulin prescribed and recently had lab that resulted in an elevated HbA1c and due to the residents' comorbidities could be negatively affected if the resident's insulin dose was not correct. The APN reported that medication administration staff are expected to administer Physician Ordered medications correctly and to follow the facility policy. The APN was asked how she provided instructions for patients related to the priming and administering of an insulin pen. She stated, I always instruct my patients to prime the pen with the point up and to hold the plunger in for a count of 5 or 6 seconds. During an interview on 09/19/25 at 10:09 AM, the Director of Nursing (DON) indicated the expectation for medication administration was for medications to be administered properly, following the medication rights and per the Physician's Orders. The DON reported that if the medication was not administered as ordered there would be a medication error. The DON confirmed that if an insulin pen was not primed correctly there would be potential for an inaccurate dose administered and the resident would not receive the ordered dose. The DON confirmed that all medications should be administered as ordered by the provider and that staff are expected to follow facility policy. The DON also confirmed that nursing competencies for medication administration were completed on hire, yearly, and as needed, and that RN #4 and LPN #3 had completed the competencies on 10/27/2025 [LPN#3] and 10/28/2025 [RN#4]. The DON reported that both LPN #3 and RN #4 had completed the competencies and were identified as being able to competently administer medications. During an interview on 09/19/25 at 10:44 AM, the Administrator reported his expectation of medications to be administered were for the medications to be administered according to Physician's Orders. The Administrator confirmed that if the medication was not administered according to the Physicians Orders, it would be considered a medication error. The expectation for staff was for them to follow the facility policies. The Administrator reported nursing competencies were performed on hire, yearly, and as needed. Review of a facility policy titled, Medication Administration with a revised date of 11/25/22, indicated that medications would be administered as prescribed to maintain a medication error rate less than 5%. Medications must be administered according to Physician's Orders. The staff administering the medications must check the label three times to ensure the right resident, right medication, right dose, right time and right method of administration prior to the administration of the medication. Review of a manufacturers document titled, Instructions for use indicated Priming your insulin pen: turn the dose selector to select two units, hold the pen with the needle pointing up, tap the top of the pen gently to allow air bubbles to rise to the top, hold the pen with the needle pointed up, press and hold the plunger until the dose shows 0, a drop of insulin should be observed at the tip of the needle. If you do not see a drop of insulin, repeat steps. Insert the needle into the skin, press and hold down the dose button until the dose counter shows 0. Keep the needle in the skin after the dose has reached 0 and slowly count to six. When the dose counter returns to 0 you will not receive the full dose until six seconds later. Review of a facility policy titled, Medication Administration with a revised date of 11/25/22, indicated that medications would be administered as prescribed to maintain a medication error rate less than 5%. Medications must be administered according to Physician's Orders. The staff administering the medications must check the label three times to ensure the right resident, right medication, right dose, right time and right method of administration prior to the administration of the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045345	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Fort Smith Rehab & Nursing Center	5301 Wheeler Avenue Fort Smith, AR 72901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled:5Number of residents cited:1Based on observations, interviews, facility in-services, and facility policy review, it was determined that the facility failed to follow proper infection control precautions during wound care for 1 (Resident #79) of 5 residents reviewed for infection control.Findings include:Based on observations, record review, interviews, and facility policy review, it was determined that the facility failed to follow proper infection control precautions during wound care for one (Resident #79) of five residents reviewed for infection control. The findings include: During a concurrent observation and interview on 09/17/2025 at 10:31AM, signage for Enhanced Barrier Precaution (EBP) was hanging on Resident 79's door. Licensed Practical Nurse (LPN) #1 came to Resident #79's room and entered with wound care supplies on a sterile tray. LPN #1 sat the tray with supplies on the bedside table and placed a red biohazard bag at the end of the resident's bed. LPN #1 applied gloves and proceeded to take off Resident #79's shoes. LPN #1 did not wash hands or put on a gown prior to initiating wound care. LPN#1 took off gloves, sanitized hands, and applied new gloves. With safety scissors, LPN #1 cut off the dressing to left foot and ankle area. This surveyor observed LPN #1 leaning over the resident's bed while providing wound care and observed that LPN #1's shirt was touching the residents' blanket on the bed. LPN #1 took off gloves, sanitized hands, and applied new gloves. LPN #1 touched the inside of the biohazard bag that had dirty items in it with gloves on, then reached over and obtained clean 4x4's from a cup with wound care solution in it. LPN #1 stated, I should not have touched the bag. I should have changed my gloves and sanitized my hands after touching the bag. It could cause more infection. LPN #1 took off gloves, sanitized hands, and applied clean gloves. An ointment was applied with a clean cotton tip applicator to the wound. LPN #1 applied betadine to the wound via swab, sanitized hands, and used clean scissors to cut the ordered medicated patch in half. LPN #1 applied the medicated patch to the wound, then applied ordered wrap to the wound. LPN #1 then gathered trash and put in trash car, took off gloves, sanitized hands and dated dressing. LPN #1 indicated, When entering the room, I should have washed my hands and put on a gown. This is to protect the resident and I from germs and infections. I am an infection preventionist. I train the staff, I should have known better. Review of an admission Record indicated the facility admitted Resident #79 on 01/19/2023. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2025, revealed Resident #79 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate cognitive impairment. Review of Resident #79's Care Plan, revised on 06/25/2025, revealed the resident had a Stage 3 Pressure Ulcer (PU) to right heel. Interventions included administer treatments as ordered and monitor for effectiveness. The Care plan also indicated that the resident required EBP due to wounds. Interventions included use of gloves and gown required prior to high-contact care. Review of an Order Summary revealed Resident #79, had on order for treatment for a stage 3 pressure ulcer to right heel. Staff were to cleanse the area with wound cleanser, pat dry, apply iodine to peri-wound, apply [an ointment used to remove dead tissue] to areas of slough, cover with calcium alginate and [abdominal] pad. Lastly, wrap with [a self-adherent wrap] every Monday, Wednesday, Friday, and as needed if soiled or missing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/2025 at 08:37 AM, the Director of Nursing (DON) indicated EBP was to be used for anything with a line that goes into the body, wounds, etc. If the staff were performing care they needed to put on their gowns and gloves. It protects the resident and staff from germs and infections. The DON stated, My understanding, you change your gloves when they are dirty, and you lay your hands on the resident. If someone touched a dirty biohazard bag they need to change their gloves. During an interview on 09/19/2025 at 09:36 AM, LPN #7 indicated, EBP means you need to be gowned and gloved to provide physical care for the resident, such as peg tube. During wound care, definitely gown and glove and if you are dealing with any bodily fluid. Gloves should be changed after you remove dressing, any time you go dirty to clean surfaces. During an interview on 09/19/2025 at 09:44 AM, Certified Nurse Assistant (CNA) #8 indicated, We use EBP when we provide care to residents that have wounds or catheters or anything like that. We know which rooms to wear gown and gloves because there would be a sign on the doors with EBP precautions. We usually only just put on a gown and glove, but sometimes shoe covers and face mask as well. If resident has a wound and we provide care we are supposed to wear gown and glove. We are trained a lot. When I got hired back I had an in-service. There are tests and pamphlets we go over. During an interview on 09/19/2025 at 10:45 AM, the Administrator indicated, when following EBP staff should follow the protocol to protect the residents from infection and protect the staff from bodily fluids that could cause the staff infections. Staff should wear gloves and gowns when preforming care. During an interview on 09/19/2025 at 10:57 AM, the Assistant Director of Nursing (ADON), indicated, EBP was to be followed anytime someone has a wound, catheter, tracheostomy (opening into the trachea to assist with breathing). The ADON indicated it was to protect the staff from getting bodily fluids on them and protects the resident also from getting any kind of infection. The ADON stated, If I was providing care I would gown and glove up as soon as I enter the room. If someone is doing a treatment they must gown and glove. I may even put on a face mask. During wound care gloves should be changed anytime the staff touch anything dirty and then return to clean. Review of a facility in-service titled, Enhanced Barrier Precautions, dated 02/18/2025, indicated, If there is a sign on a resident's door EVERYONE MUST follow the EBP. Enhanced Barrier Precautions (EBP) are a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs). EBP are used in nursing homes and other long-term care facilities. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employees targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Review of a facility policy titled, Enhanced Barrier Precautions (EBP), revised on 03/21/2024, indicated, EBP requires gowns and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organism (MDRO) to staff hands and clothing. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: Wound care: any skin opening requiring a dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility in-service titled, Enhance Barrier Precautions, dated 05/26/2025, indicated, A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to $483.70(e) and following accepted national standards. Review of a facility policy titled, Infection Control, revised on 11/02/2022, indicated, Prevention of infection following established general and disease-specific guidelines such as those of the Centers for Disease Control.